AN ACT relating to Medicaid credentialing of health care providers.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔Section 1. KRS 205.532 is amended to read as follows:

(1) As used in KRS 205.532 to 205.536:

(a) "Clean application" means***:***

1. For credentialing purposes, a credentialing application submitted by a provider to a credentialing verification organization that:

a. ~~[1.]~~ Is complete ***and correct***;~~[and]~~

b. ~~[2.]~~ Does not lack any required substantiating documentation; ***and***

c. Is consistent with the requirements for the National Committee for Quality Assurance requirements; or

2. For enrollment purposes, an enrollment application submitted by a provider to the department that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation;

c. Complies with all provider screening requirements pursuant to 42 C.F.R. Part 455; and

d. Is on behalf of a provider who does not have accounts receivable with the department;

(b) "Credentialing application date" means the date that a credentialing verification organization receives a clean application from a provider;

(c) "Credentialing verification organization" means an organization that gathers data and verifies the credentials of providers in a manner consistent with federal and state laws and the requirements of the National Committee for Quality Assurance. "Credentialing verification organization" is limited to the following:

1. An organization designated by the department pursuant to subsection

(3)(a) of this section; and

2. Any bona fide, nonprofit, statewide, health care provider trade association, organized under the laws of Kentucky, that has an existing contract with the department or a managed care organization, as of July 1, 2018, to perform credentialing verification activities~~[for its members, providers who are employed by its members, or providers who practice at the members' facilities]~~;

(d) "Department" means the Department for Medicaid Services;

(e) "Medicaid managed care organization" or "managed care organization" means an entity for which the department has contracted to serve as a managed care organization as defined in 42 C.F.R. sec. 438.2;

(f) "Provider" has the same meaning as in KRS 304.17A-700; and

(g) "Request for proposals" has the same meaning as in KRS 45A.070.

(2) On and after January 1, 2019, every contract entered into or renewed for the delivery of Medicaid services by a managed care organization shall be in compliance with KRS 205.522, 205.532 to 205.536, and 304.17A-515.

(3) (a) Through a request for proposals, the department shall designate a single organization as a credentialing verification organization to verify the credentials of providers on behalf of ~~[the department and]~~all managed care organizations.

(b) Following the department's designation pursuant to this subsection, the contract between the department and the designated credentialing verification organization shall be submitted to the Government Contract Review Committee of the Legislative Research Commission for comment and review.

(c) A credentialing verification organization***, designated by the department,*** shall be reimbursed on a per provider credentialing basis by the department. ***The reimbursements***~~[This expense]~~ shall be ***offset or deducted equally***~~[reduced]~~

from ***each*** Medicaid managed care organizations capitation ***payments***~~[rates]~~.

(d) ***The department shall enroll and screen providers in accordance with 42 C.F.R. Part 455 and applicable state and federal law.***

(e) Each provider seeking to be enrolled and screened with the department shall make application via electronic means as determined by the department.

(f) Pursuant to federal law, all providers seeking to participate in the Medicaid program with a managed care organization shall be enrolled as a provider with the department.

(g) Each provider seeking to be ~~[enrolled in Medicaid and]~~credentialed with ~~[the department and]~~a Medicaid managed care organization shall submit a single credentialing application to the designated credentialing verification organization, or to an organization meeting the requirements of subsection (1)(c)2. of this section, if applicable. The credentialing verification organization shall:

1. Gather all necessary documentation from each provider;
2. Within five (5) days of receipt of a credentialing application, notify the provider in writing if the application is complete;
3. Review an application for any misstatement of fact or lack of substantiating documentation;
4. ***Credential and*** provide verified credentialing ***information electronically***~~[packets]~~ to the department and to each managed care organization as requested by the provider within thirty (30) calendar days of receipt of a clean application; and
5. Conduct reevaluations of provider documentation when required ***pursuant to***~~[by]~~ state or federal law or for the provider to maintain participation status with ~~[the department or]~~a managed care

organization.

(4) (a) The department shall enroll a provider within ***sixty (60)***~~[thirty (30)]~~ calendar days of receipt of a ***clean provider enrollment application***~~[verified credentialing packet for the provider from a credentialing verification organization]~~. The date of enrollment shall be the date that the provider's clean application was initially received by ***the department***~~[a credentialing verification organization]~~. ***The time limits established in this section shall be tolled or paused by a delay caused by an external entity. Tolling events include, but are not limited to, the screening requirements contained in 42 C.F.R. Part 455 and searches of federal databases maintained by entities such as the United States Centers for Medicare and Medicaid Services.***

(b) A Medicaid managed care organization shall:

1. Determine whether it will contract with the provider within thirty (30) calendar days of receipt of the verified credentialing ***information***~~[packet]~~ from the credentialing verification organization; and

2. a. Within ten (10) days of an executed contract, ensure that any internal processing systems of the managed care organization have been updated to include:

i. The accepted provider contract; and

ii. The provider as a participating provider.

b. In the event that the loading and configuration of a contract with a provider will take longer than ten (10) days, the managed care organization may take an additional fifteen (15) days if it has notified the provider of the need for additional time.

(5) ***(a)*** Nothing in this section requires a Medicaid managed care organization to contract with a provider if the managed care organization and the provider do

not agree on the terms and conditions for participation.

(b) Nothing in this section shall prohibit a provider and a managed care organization from negotiating the terms of a contract prior to the completion of the department's enrollment and screening process.

(6) (a) For the purpose of reimbursement of claims, once a provider has met the terms and conditions for credentialing and enrollment, the provider's credentialing application date shall be the date from which the provider's claims become eligible for payment.

(b) A Medicaid managed care organization shall not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and a managed care organization's completion of its credentialing process.

(c) Nothing in this section shall limit the department's authority to establish criteria that allow a provider's claims to become eligible for payment in the event of lifesaving or life preserving medical treatment, such as, for an illustrative but not exclusive example, an organ transplant.

(7) Nothing in this section shall prohibit a university hospital, as defined in KRS 205.639, from performing the activities of a credentialing verification organization for its employed physicians, residents, and mid-level practitioners where such activities are delineated in the hospital's contract with a Medicaid managed care organization. The provisions of subsections (3), (4), (5), and (6) of this section with regard to payment and timely action on a credentialing application shall apply to a credentialing application that has been verified through a university hospital pursuant to this subsection.

(8) To promote seamless integration of licensure information, the relevant provider licensing boards in Kentucky are encouraged to forward and provide licensure information electronically to the department and any credentialing verification

organization.